PRINTED: 11/08/2012
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1601	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 831	1200-8-6-.08 (1) Building Standards (1) A nursing home shall construct, arrange, and maintain the condition of the physical plant and the overall nursing home environment in such a manner that the safety and well-being of the residents are assured. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the nursing home environment. The finding included: On 11/5/12 at 10:30 AM, observation within resident rooms 405 and 500 revealed the finished veneer on the entry doors were damadged by wheel chairs/carts. On 11/5/12 at 11:15 AM observation within resident room 602 revealed there was a missing ceiling tile in the closet. These findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 11/5/12.	N 831	N831 The entry doors to rooms 405 and 500 have been repaired. All entry doors have been inspected and all doors with damaged veneers have been identified. Repair of these doors has begun and will be completed by the Maintenance Director before12/10/2012. The ceiling tile in room 602 was immediately replaced. The Maintenance Director and the Chief Executive Officer will review all entry doors for veneer damage, and the presence and placement of ceiling tiles, on a daily and ongoing basis and review in the scheduled monthly safety meeting.	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 11/20/12

STATE FORM 6899 7J2Q21 If continuation sheet 1 of 1